DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/19/2015 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS HEALTH CARE CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (ROUND INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Receptification and State Licensure Survey conducted on 09/10/15 and a Quality Assurance Walk-thur Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/15/15 Facility Number: 000447 Provider Number: 155551 AlM Number: 100289950 At this PSR survey, Rolling Meadows Health Care	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER ROLLING MEADOWS HEALTH CARE CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) [K 000] INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Conducted on 09/10/15 and a Quality Assurance Walk-thur Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/15/15 Facility Number: 000447 Provider Number: 155551 AIM Number: 100289950			155551 B. WING						
ROLLING MEADOWS HEALTH CARE CENTER LA FONTAINE, IN 46940 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) [EACH OF THE APPROPRIATE DEFICIENCY) [K 000] INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/10/15 and a Quality Assurance Walk-thur Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/15/15 Facility Number: 000447 Provider Number: 155551 AIM Number: 100289950	L 1111					STREET ADDRESS, CITY, STATE, ZIP CODE	1 10/	13/2013	
CA4 ID PREFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION CEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE [K 000] INITIAL COMMENTS {K 000} A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 09/10/15 and a Quality Assurance Walk-thur Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/15/15 Facility Number: 000447 Provider Number: 155551 AlM Number: 100289950 Alm Number: 10028950 Alm Number:						604 RENNAKER ST			
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{K 000} INITIAL COMMENTS				1	X	(EACH CORRECTIVE ACTION SHOULD B		COMPLETION	
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Facility Number: 000447 Provider Number: 155551 AIM Number: 100289950			Health in accordance with 42						
Provider Number: 155551 AIM Number: 100289950		Survey Date: 10/15/1	5						
AIM Number: 100289950		Provider Number: 155551							
At this PSR survey, Rolling Meadows Health Care									
		At this PSR survey, Rolling Meadows Health Care Center was found in compliance with Requirements for Participation in							
Requirements for Participation in									
Medicare/Medicaid, 42 CFR Subpart 483.70(a),									
Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101,									
Life Safety Code (LSC), Chapter 19, Existing		Life Safety Code (LSC	C), Chapter 19, Existing						
Health Care Occupancies and 410 IAC 16.2.		Health Care Occupan	icies and 410 IAC 16.2.						
This one story facility was determined to be of		-							
Type III (211) construction and was fully		·	•						
sprinklered. The facility has a fire alarm system with smoke detection in the resident rooms.									
corridors and areas open to the corridors. The									
facility has a capacity of 115 and had a census of 90 at the time of this survey.									
The facility was found in compliance with state		The facility was found	I in compliance with state						
law in regard to sprinkler coverage and smoke detector coverage.		law in regard to sprink	•						
All areas where residents have customary access		All areas where reside	ents have customary access						
were sprinklered. The facility had three detached sheds providing facility services including the		•	•						
LABORATORY DIRECTOR'S OR PROVIDER/SLIPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE								(VO) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCT NG 01	ION	(X3) DATE SURVEY COMPLETED	
		155551	B. WING			1	₹ 15/2015
	ROVIDER OR SUPPLIER			STREET ADDRE		1 10/	19/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B DSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{K 000}	Continued From page maintenance supplie chairs that were not so Quality Review on 10	s, activity supplies and wheel sprinklered.	{K 0	00}			